Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Phillip W. Landes, MD

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-15-1782-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
February 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am in receipt of an EOB denying payment for this bill for a Designated Doctor Exam, which states: 'SERVICES NOT TIMELY FILED BY THE PROVIDER.' However, this is incorrect.

This bill was electronically submitted to the carrier's e-billing clearinghouse account (#19046) on December 26, 2014 – the 95th day after the date of service. Please see the underlined time-stamp in the top right hand corner of the CMS-1500. The report was faxed to the adjuster on December 23, 2014, to the fax number listed on the DWC-32.

We billed a total of $2,750.00 for the services provided. *We have received no payment from your company.* **Please issue a prompt payment of $2,700.00 to settle this claim.**"

Amount in Dispute: $1200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for A Designated Doctor evaluation. The Provider performed services and submitted billing to the Carrier. The Carrier reviewed the billing and denied reimbursement based on the failure to timely submit the medical billing. The provider filed a request for reconsideration and subsequently filed this Request for Medical Fee Dispute Resolution seeking additional reimbursement.

The Provider contends they are entitled to reimbursement for the services at issue. The Carrier has reviewed the file and agrees that reimbursement is due. The Carrier is issuing reimbursement in accordance with the Division-adopted fee schedule.

With the reimbursement being issued, the Carrier contends the Provider is not entitled to additional reimbursement. The Carrier, therefore, respectfully requests the Provider withdraw this Request for Medical Fee Dispute Resolution upon receipt of the reimbursement, or in the alternative, that the Division determine no additional reimbursement is due for this service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2014	Designated Doctor Examination	$1200.00	$270.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §133.240 sets out the procedures for reimbursement or denial of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – Not defined as required by 28 Texas Administrative Code §133.240.
   - 937 – Services not timely filed by the provider
   - 16 – Not defined as required by 28 Texas Administrative Code §133.240.
   - Z001 – For explanation of a non-pymt by the adj, please contact the adjuster on file.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. What is the total allowable for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR and total allowable for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area. (D) …(i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides… (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the lower extremity to find the Impairment Rating, and provided an impairment rating for depression. Therefore, the correct MAR for this examination is $450.00. However, the requestor billed only one unit. Therefore the total allowable for this examination is $300.00

   Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury. Therefore, the correct MAR and total allowable for this examination is $500.00.

   Per 28 Texas Administrative Code §127.10 (d), "…If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury…If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor's extent of injury determination..."

   Furthermore, 28 Texas Administrative Code §134.204 (j)(4)(B) states, "When multiple IRs are required as a component of a designated doctor examination … the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code." The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and

enclosed forms support that these examinations were performed, and multiple impairment ratings were provided appropriately. Therefore, the correct MAR for this service is $50.00 per additional IR. Because the requestor provided one additional IR, the total allowable is $50.00.

Per 28 Texas Administrative Code §134.204 (j)(4)(D)(iii) states, "When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply: (I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination." The requestor referred the injured employee to a specialist to provide a report to aid in determining the IR for depression. The use of this report is noted in the narrative. Therefore the correct MAR for this service is $50.00. However, the requestor has requested $0.00 for this service. Therefore, the total allowable is $0.00.

2. Review of the submitted documentation finds that the total allowable for the Designated Doctor Examination in question is $1200.00. The insurance carrier paid $930.00. Therefore an additional reimbursement of $270.00 is recommended.

Billed Code	Total Allowable	Insurance Paid	Amount Due
99456-W5-WP (MMI)	$350.00	$350.00	$0.00
99456-W5-WP (IR)	$300.00	$30.00	$270.00
99456-W6-RE	$500.00	$500.00	$0.00
99456-MI	$50.00	$50.00	$0.00
99456-SP	$0.00	$0.00	$0.00
Total	$1,200.00	$930.00	$270.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $270.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $270.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 15, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.